# Raising our voice: perspectives on suicide in the LGBTI community

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## Suicide: finding a voice

Suicide is a maligned word. The act is tainted; for many years in Western cultures it was deemed illegal, a crime against the self. The victim's body was denied a Christian burial, their estate placed in legal jeopardy. For family that remained, the stigma could survive for generations. Yet, despite the increasing secularisation of Western society, and the encroachment of science — with its objective, rational mode of enquiry — the opportunity to talk about suicide remains proscribed. The findings of mental health professionals researching in this area are available only within a closed circle of private space bounded by subject-specific scientific literacy. And in the public space of newspapers, the euphemism "no suspicious circumstances" halted discussion until only a few years ago. (Weaver and Wright 2009; Marsh 2010). In private, the silence remains deafening.

But what might have been said? The irony of suicide is that the experience could never be subjectively verified; the person was no longer alive to add to the discussion. What remained of their identity would collide with the bureaucratic instruments set up to police and manage the aftermath. Formal identification and autopsy might place the person within the pathology of forensic science

through dissection, reduction, and re-substantiation. If they were to receive a formal burial, religion might stake a claim, on either body or soul, or both. As the memories of those left behind might fade, the person would appear to diminish further. Outside of this grief, they would be reduced to a single point of existence: a statistic.

In a further irony, the hallmark constituents of suicide — stigma and silence — are also shared by people living within Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) communities. However, this is not experienced consistently. Some experiences are loudly and proudly recounted: the devastation and subsequent community response to the HIV epidemic is the most prominent (Power 2011). Yet, it is told in a story circle of people who remain marginalised and muted, incapable or unwilling to face the ever-present mental health crisis. As the research space into the phenomena of suicide is growing, the LGBTI community have become the 'object' of study, rather than the voice, and loved ones still face the challenge of their situation being treated as a statistic.

This paper aims to recover some of those unspoken voices. We respect that formal academic writing, especially in the sciences, places objective methodological hygiene above subjective personal narratives (Dean and Smith 2009). However, we also acknowledge that literature and literary studies, in recognising the primacy of the narrative, can act as both a starting point for the individual to connect with the collective, and as a bridge, a vehicle of meaning. To respect both of these approaches we have chosen to express our findings through memoir. This genre allows us to blend our respective methodological backgrounds and weave our individual experiences into a discontinuous yet integrated commentary on the statistics that haunt our community. We hope to create a space to recover some of those lost voices — and claim this journal as a site of that recovery — while making meaningful connections for other researchers interested in the legitimacy of the personal narrative.

Because suicide has touched all of the authors, we were especially mindful when crafting our choice of voice. In some parts, we relay individual experiences,





and use a first-person voice. In others, we use a combined voice: the corporate "we". However, while that may imply unanimity, we are also aware that at times it is because one of us may need anonymity, and wishes to draw strength from the collective shield of the others. This approach is also informed through our experience of working in mental health, where we are acutely aware of the stigma associated with personal experience, and the corollary restriction that we remain detached and objective when dealing with subjective experiences. Although we have all written policy documents, training information and frameworks that have required us to write using an objective corporate "we" (see for example Mars, Morris, and Marchesiello 2013) in this paper we are, in part, the object of our own study; our voice is both an act of courageousness and an expression of mutual respect.

Our choice of voice also acknowledges the evolution and current standing of voice within the LGBTI community. When new social movements arise, particularly when people who were previously marginalised are coming to voice, an identity as an "authentic" embodied member of the community is considered important. Within the community we have witnessed this in the constantly evolving initialisms: GLB, LGB, LGBT, LGBTI. We do not challenge whether LGBTIQ is the latest incarnation. As social movements progress we tend to see a softening of the boundaries around identity and changes to the particular identities that occupy positions of privilege within tightly defined hierarchies of oppression. Currently, for example, trans and intersex people are often missing in evidence-based research, while bisexual people are often vilified or overlooked in the community at large.

With the theme of Death and the Maiden as our guide, we have chosen collectively to reclaim a self-consciously feminine voice, which we believe has been lost, as other identities within the LGBTI community have come to occupy privileged positions. We are not suggesting that the voice of the feminine is embodied in any particular form. For the three of us, when writing ourselves as a collectivised voice, the "I" of who we are — and how we see ourselves in the gender continuum — is vastly different. However, as subjects engaged in a

continuous struggle with the transgression of bodily boundaries, what we share in common is a reluctance to claim our expected gender roles and identities. We also claim no privilege in our choice, only a desire to give everyone who wants to contribute a chance to be heard on equal ground.

## Getting personal: reluctant stories

My work within the LGBTI community has often revolved around mental health and suicide prevention, yet for a long time I have told myself that this was somewhat incidental. As a youth worker I supported the learning of life skills to navigate towards adulthood; as a mental health worker I supported people to become more aware of their internal world and move towards wellness; and as a community development worker I supported people to find and create community where they can connect. However, if I am honest with myself, the thread that connected much of my work was supporting people to simply survive and to find a space in the world where they could be safe.

All of us who continue to work in this space have something that motivates us. I work hard in all of my roles in the community, paid and volunteer alike, feeling a sense of obligation to work longer and harder for those that look to me for support. I get so much joy and satisfaction from being witness to the growth and learning of those in my LGBTI community. I see them through fragments of their often-tremulous journeys, and try to steady them through the difficult spaces. I feel a huge sense of relief when I then see them experience a sense of wellbeing, connection and belonging.

But underlying this is so much more that drives me: a real truth of mine, a story I really don't want to tell. I am much more comfortable with statistics, the impact of sheer numbers. But these numbers are people who we've known, cared for and loved: people who were a part of our community and a part of our lives. I've waited nearly seven years to write this story down for others to read. Writing it isn't the problem; it's with me every day. The real questions are these: Am I ready for everyone to know what is underneath the surface?





Am I ready to be exposed and made vulnerable to others who are reading my words?

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I kept diaries from an early age because the words comforted me. As a teenager, and newly arrived migrant to Australia, I missed the co-ed school of my homeland. Most of my friends had been girls, and in this all-male enclave I was a perpetual outsider. I recorded completed homework and academic achievements, a facade of perfection reinforced by magic words: school reports, with letters high in the alphabet and the encouraging words of oblivious teachers.

I didn't record the bullying. Sitting down, and having the person next to me instantly move away. A chorus of sniggers accompanying each time I spoke. Accent mimicry. Names. This was a school that taught me that AIDS meant, "arsehole-injected-death-sentence". I learnt about safe sex from my female form teacher. The sniggers this time were directed at the unripe banana, which she used to demonstrate her technique to correctly unroll a condom. Blushing — I felt her shame as my own — she invited one of my classmates to reproduce her handiwork. He ripped and rolled effortlessly, smirking the whole way through. If these boy-men ever explored each other's bodies or desires, I remained oblivious. Besides, we would never have been able talk about it; we had no words.

I blossomed in the freethinking arena of university, just as homosexuality was decriminalised and queer theory found its form. But before long I had caught a man's eye. He said he worshipped me, and showered me with attention. He said my friends weren't worthy of me, and I found it harder and harder to keep their contact. He said my family didn't understand him, and I saw them less and less. At the end of that first year he tried to strangle me, telling me "this is where you die for not listening". Shortly after, in the first honest conversation my mother and I had ever had about my 'new' life, she asked me, "who is the woman in the relationship?" Her lack of understanding was

only one step behind my own.

Unable to imagine any other options I returned to the relationship, and kept a separate life in words. I mimicked the angst and desperation of Kenneth Williams, whose diaries openly spoke of his desire to kill himself (Williams 1993). I read their 800-plus pages over and over. But one day my volumes were discovered. The man-who-strangled filleted their contents, quoting relentlessly to prove my worthlessness during inquisitions than ran for hours. In a fit of panic I burnt everything. Afterwards, without my comforting words, all I could hear was his taunting voice in my head; the wrenching in my guts stayed with me night and day.

It never occurred to me to call these actions domestic violence until a nurse I worked with confided to me that her son was being physically and verbally abused by his wife. The nurse had no idea how to get help. I wondered: could men be victims? This tiny breathing space helped me quantify the enormity of what I had befallen. Taunts, put-downs, public humiliations, and, more lately, intense monitoring and physical restraint, had all increased by degrees: occasional at first, and always with apology, until they came to characterise the relationship itself. The revelations unravelled my tightly corseted façade. Fifteen years after my mother first asked me her honest question, she accompanied me to her local hospital's emergency department. She knew there was something wrong. She sat with me patiently, for hours, waiting to be seen. And I told her what I was planning.

## An evidence-base: the LGBTI statistical sampler

Sexual orientation by itself is not the primary determinate of suicide rates and poor mental health for these woman, rather it is the social determinates that they suffer as a result of this. Experiences of oppression that remain unspoken and unspeakable over time are themselves social determinants as are the stressors associated with coming out (Hillier et al. 2008), the added likelihood of homelessness, higher use of alcohol and other drugs, experiences





of lateral violence within the community, and even the lack of evidence-based research and publication of material. Although we now have options in how we talk about gender and sexuality, and how we understand ourselves, these social determinants have very real effects on the lives on LGBTI people.

But even the social determinants cannot explain the whole story, because underneath this interpretation sit more subtle forces: a shifting understanding of theory, philosophy, and even spirituality, that colours over time how we interpret information about gender and sexuality. I am a part of this iterative process. My philosophical underpinning began with a feminist English teacher in the late 1970s. However, it wasn't until university in the 1980s that I began to unpack the biological essentialism inherent in that brand of feminist thinking. I found Luce Irigaray, a fur-coat wearing French philosopher who spoke of sexy things like labia, and wrote controversially about it. Our lips spoke together. Next, I encountered Michel Foucault, a post-structuralist who made me think about the constructed nature of truth through dominant and resistant discourses. Further revelations in my thinking came with Judith Butler and Queer Theory. I witnessed, and was a part of, a discursive journey in universities where women's studies morphed into feminist studies, in turn spawning and evolving into gender studies, and then gender and sexuality studies. Stepping out of the academy, I know that evolution has continued.

The literature on women and suicide tells us that there are higher rates of suicide amongst women in the LGBTI community than in the population in general. However, the magnitude can only be conceived in comparison. At the broadest level, LGBTI people have the highest rates of suicidality of any population in Australia. 15.7% of lesbian, gay and bisexual Australians and 20% of trans Australians report current suicidal ideation. Same-sex attracted Australians have up to fourteen times higher rates of suicide attempts than their heterosexual peers. Rates are six times higher for same-sex attracted young people, 20-42% cf. 7-13%. The average age of a first suicide attempt is 16 years, often before "coming out" (Rosenstreich 2013). The ages and life stages reflected in the statistics have changed over the years but the underlying problems remain.

I can look back now and see that we live in a world where the things we took for granted, even thirty years ago, no longer hold the same sway: the whole notion of binary gender upon which 70s feminism rested has been unpacked. Legally, in Australia, gender has been redefined so that people can choose to be recognised as intersex, exist on a gender continuum of their choosing, and not have to conform to one fixed gender, or even one gender or another.

Yet despite these apparent advances, the statistics paint a bleak story. What the statistics mean to me is that I know and love a lot of people who have mental health issues and think and talk about suicide. In my everyday work, I choose now to address the social determinants of health at the site of the practical everyday changes, specifically where I know those changes can be made: mainstream mental health provision. This is necessary and vitally important, but there is more that can be done.

Postmodern, post-structural and post-colonial theorists made me think through the layers of what we know, and how we come to know. We can't just take things for granted, only looking at the social determinants of health and stopping there, because social determinants are currently fashionable within the rhetorical enclaves of health's dominant political discourse. We need to look underneath, interrogate our thinking, interpolate the dominant discourses and transform the discourse at the site of power (**Al-Quaderi** 2011). For example, if we think about the colonisation of our own thinking, how much do we as a community mirror the violence we experience in our everyday interactions with one another? We don't often interrogate ourselves as a community. We could argue that self-critique is difficult in the context of all the phobias we are often subject to. Yet without reflection, the "bitching" and criticism that are rife in my community remain endemic.

Lateral violence is an acknowledged determinant of poor mental health in LGBTI community groups and as a result power struggles are a perennial issue. Power struggles often isolate individuals and divide groups. People slip away. Lack of community is a contributor to poor mental health for LGBTI people





and poor mental health can be a precursor of suicide. My knowledge, via my theoretical understanding, when combined with my experience, has left me asking questions of myself. Specifically, when I consider the stories in this paper, I ask myself: What can I do?

## Wendy: one woman's story

Most people who know me now have never met Wendy. People in my life that knew her have all moved out of my life for a range of reasons — some at my insistence — and so there is always discomfort when this conversation arises. It happens in one of two ways. The first way is when someone asks me if I have any brothers and sisters. A range of possible answers will run through my head as I try to decide how to respond. Will a simple yes suffice? Will there be more questions? How much do I want to share with this person? Is it necessary or important that they know? What reaction am I likely to receive? Do I really want to be having this conversation? Do I want them to "meet" Wendy? The other way is when I have a momentary lapse where I recall a memory or retell a story, and forget my audience. When someone asks "who's Wendy?", it's a stark reminder that not everyone knows her. I am faced with the same dilemma that the first question brings up.

Wendy is two years younger than me. We spent our childhood building cubbyhouses with tables, sheets and string; riding our bikes around the local streets collecting macadamia nuts from the neighbours' trees; driving our matchbox cars around chalk-drawn roadways on the garage floor; and saving up our pocket money to buy paper bags of lollies from the corner store. Growing up we looked so similar to each other — being the same height and with the same slim build, fair skin and blonde hair — that we often got confused for twins. I hated this as I was supposed to be the big sister, stronger and more confident. But often this wasn't the case, with Wendy taking the lead.

As we got older Wendy created a unique and distinguished image for herself: bold, black-rim glasses, tattoos and stretch earrings, leather jewellery, along

with big black boots and jet black hair that she would wear in short, messy pig-tails. In contrast, I always felt so awkward. I would choose to blend in to the background, being quiet and controlled. Not wanting to draw attention to myself. Not wanting to upset the space around me. Yet, even if I saw myself as the good girl, and Wendy the rebel, we still had a sister's bond that cut across all divides.

Even though it wasn't something we spoke about growing up, I recognised she was more like me than I realised when I found out she was gay. In this moment she became my "Lil' Queer Sis". Although I always had an inkling that I was different to most other children my age, Wendy never seemed to share my awkwardness or isolation, with a never-ending stream of friends drawn to her confidence and bubbly personality. Her "coming out" to me in our early twenties was a shock, even more so than my own realisation of my sexuality in my mid teens.

Once this initial shock had passed, having a gay sister was an awesome experience. From feeling so very alone in realising my difference — with all the fears and anxiety about not fitting in — I was suddenly not the only one in my family who was different. We supported each other as we challenged all the expectations of who we were supposed to be. Some of my most treasured memories of Wendy are after we made this connection. At the Brisbane Pride Festival we would walk together in the march from the City to Musgrave Park. I always found it so amusing that every year she would wear clothes that wouldn't keep her warm enough from the cold June winds, shivering throughout the day, but never complaining because she knew her outfit looked perfect.

My enduring image of Wendy is as a really gentle and caring person, with deep feelings and an enormous capacity for compassion. She loved animals. Her study of native animals and work at wildlife parks gave her so much joy. When watching her give a talk to a group of tourists about the animals she cared for, it was evident that she was in her element. Yet even when I recollect my memories I'm aware they are filtered. If I am to present a rounded picture, I





have to be honest about the parts that aren't so happy to recall.

Depression is common throughout our family. We never spoke openly about how this impacted on us, but we all adjusted to having its presence in our lives; although not with any particular skill or grace. Wendy, although so vivacious, also experienced such sadness. She would use drugs and alcohol to cope with the enormity of her feelings. When she started smoking I became increasingly concerned because she was always such a strong critic; our Grandpa died of lung cancer only months before she was born and as a child she would feign coughing behind strangers who were smoking. Wendy craved love: to be loved, to feel loved, to be loveable. She never really recovered from a breakup with her long-term girlfriend and she spiralled down into a deep depression. It seemed, for a while, that she would never bounce back.

## Women interrupted: the story in the evidence

While all people of all LGBTI subgroups may be at a higher risk of suicidal behaviours than non-LGBTI people, some subgroups seem more vulnerable than others. In particular, trans people, especially if they are "out" as trans, seem to be at very high risk. Intersex people are also very vulnerable, having often been through years of forced medical interventions. Bisexual people, possibly because they do not fit neatly into heterosexual or gay/lesbian identities, can also experience high levels of rejection, leaving them feeling left out, leading to more frequent suicidal behaviours than lesbian women and gay men.

The incidence of suicidal thoughts, suicide plans, and suicide attempt is higher for "homosexual/bisexual" men *and* women, than heterosexual people. Strikingly high is the proportion of lesbian and bisexual females who have attempted suicide: almost one in five. Researchers used data from the Australian Longitudinal Study on Women's Health Survey and found that "life was not worth living" for more mainly-heterosexual, bisexual, and lesbian women, than heterosexual women (Hughes, Szalacha, and McNair 2010). Self-harm was also higher for all three groups.

There are certain factors associated with suicidal behaviours in LGBTI people that are shared with non-LGBTI people. One is substance abuse, there is evidence that substance use is higher in gay men than heterosexual men, and lesbian women are more likely to experience alcohol abuse than heterosexual women (McDaniel, Purcell, and D'Augelli 2011). Illicit drug use has also been found to be a related factor to LGBT death in Australia (Skerrett et al. in press).

However, most evidence points to specific risk factors related to homo/bi/transphobic prejudice. These begin with the developmental stressors: "coming out" in adolescence and early adulthood, and the fear of rejection and anxiety this brings. Unlike other cultural and linguistic minorities, LGBTI individuals usually do not share their minority status with their parents, often leading to socialisation in gay bars and clubs, potentially making the risk of alcohol and drug abuse greater (Suicide Prevention Australia 2009).

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Wendy had a suicide attempt that landed her in the emergency department of a hospital; waiting for over eight hours to see if she was all right was unbearable. However, it wasn't deemed serious enough for her to be admitted. Perhaps they didn't really take her grief over her relationship loss that seriously? There was little further follow up from the mental health system. Admitting that she needed support, and believing she was worthy of care, wasn't in Wendy's nature. Even though we are a relatively close family, there to support each other when needed, she didn't want our parents to know about her suicide attempt. This fitted well with our family habit of not talking about our feelings of the big things that really mattered.

Wendy and I had lived together on and off over the years. My home was often a place where she would return to when she needed somewhere to stay. I enjoyed being the big sister who was able to provide this space in the world where Wendy felt safe, even though we would clash when she would rearrange my house without my permission. She moved back in with me after





her suicide attempt because I wanted to support her and look after her like a big sister should. I wanted her to see a counsellor. I had just started to unpack the sadness that was creeping into my life after our parents' negative response to our coming out to them. I thought it would help her. However, by this time she had given up her job with her animals and wasn't able to afford the cost.

Even though at this time I was working as a youth worker, providing support to others with quite complex needs, it was another story trying to apply this framework to my sister who was struggling with ongoing depression, anxiety and suicide ideation. I didn't realise how ill-equipped I was for this task. Yet our days spent together had a degree of normality, though with time the memories have faded. I remember that Wendy built a vegie patch where she tried to teach me not to kill plants. We would hang out watching television series that we loved, cooking meals and sharing stories of our day with each other. We marched in the Brisbane Pride Festival, but only a few weeks later she tried, once again, to take her own life.

## Women emerging: a trans perspective

Transphobic stigma in Australian society means that trans women are particularly vulnerable to poor mental health and suicidal ideation and suicide attempts, even when compared with other sectors of the LGBTI community (Hillier et al. 2010; Pitts et al. 2006; Mitchell et al. 2012; Couch et al. 2007). Issues that are particularly relevant to trans women centre on body dysmorphic issues. For example, although we may not usually connect plastic surgery with saving lives, a recent Swedish study by the Swedish Federation for Lesbian, Gay, Bisexual, and Transgender Rights showed that psychological complications for those forced to live with a body that doesn't match their gender identity are high; the suicide rate among patients denied breast implants is 30 to 40 percent, compared with only 1.6 percent for the general Swedish population (Anderson-Minshall 2012).

The link between coming out and suicidal ideation is also well established; this

is magnified for many trans women as they experience the stress of coming out every time they leave the house. Getting dressed with friends to attend an event is often just as much fun as the event itself, but it can also be highly stressing if your friends happen to be trans women. “Doing” another gender and passing requires a great deal of skill. It is often time consuming, emotionally challenging, and for some not an easy thing to achieve. Attitude and appearance can alleviate stress: some people pass easily as another gender, some don’t want to pass and deliberately want to look trans, while some are comfortable playing with their identity. However, some people will never pass, and struggle to find a psychological equilibrium.

Stressors can manifest in the most apparently trivial of issues; once you are out, gender-segregated toilets can become a battleground. I have had to explain to bouncers how insulting it is to trans women to be told they can’t use the women’s toilets at gay events because they deemed a man; that they can only use the women’s toilets if they have had “the operation”. In more mainstream venues I’ve waited outside the men’s toilets because I’m worried my friends might get into trouble and need help. If I invite someone on a date I will always choose a fine dining restaurant where I know the service will be professional, and if I haven’t been there before I will check out the staff first to see if they are going to be cool with my date. While I’ve been on some good dates, it’s the negative experiences of going out that stick in my mind: being chased while trying to find transport, come-ons from taxi drivers, and, once we’ve reached our destination, violence following derogatory questions from ignorant young people about my “he-she” companion.

Violence remains the most corrosive stressor. We know that violence against women increases the risk of suicide (Lhomond and Saurel-Cubizolles 2006), and that higher rates of violence against trans people place them at high risk of attempting suicide (Maguen and Shiperd 2010). Recent research demonstrated that sexual and physical violence directly correlated with suicide attempts and ideation in trans women, with an alarming 26.3% of trans women reporting a history of suicide attempts (Testa et al. 2012). The reality for me means that a





few months ago I went out on a Friday night and had a chat to someone who seemed in good spirits. The next day I found out via Facebook that she was dead. Her wake was held a few weeks later in a pub down the road from the club we had spoken in. Everyone was shocked. A period of hyper-vigilance followed. Everyone moved to suicide watch on Facebook. Posts were monitored, and it became almost impossible to speak of simply having a bad day without negative implications being drawn.

Living in “the community” and working in suicide prevention means we live the statistics on a daily basis. We experience violence, both external and lateral, and live in a community with people whose lives are much more likely to be broken than those in the general Australian population. We ourselves are subject to the negativity and bigotry of others, yet we remain reluctant to unpack and expose our own lived experiences.

**Staying personal: reluctant stories speak out**

It was my father, ultimately, who saved me. He was dying, and he needed my help to care for him. The process had been gradual: a damaged heart whose left side was slowly detaching from the ventricular plumbing that sustained it. More and more of his life-giving blood was leaking inside his body, failing to find his vital organs. But he refused to give in. How I longed to swap places with him. He was welcome to my heart because, if I was honest with myself, I had no use for it at all. My brush with hospital had failed to convince me otherwise. I just had to bide my time until he was gone.

But my father had been placed on a transplant waiting list. Suddenly we were surrounded by people with other people’s hearts beating inside them. They swooped on my father, via a hospital buddy system, to make sure he stayed calm and positive while waiting. Although he’d grown small and hunched he crackled with a new-found energy, feeding off their positivity. With nothing to lose, he told me exactly what he thought of my relationship, and what he thought I should do. He apologised for taking so long to tell me. And then the

right side of his heart started to fail. The next person I met was a palliative care nurse.

I went home that night full of regret. I had been unable to feel anything for years, permanently numbed by a relationship that had left me hollow. I was dreading the next morning, but unknown to me, some choices had already moved beyond my control. On the other side of the country someone died. As I dreamt, their heart was sped by chartered flight to its new life. By ten o'clock the next morning my father was in an operating theatre, the heart that he had used so honestly the day before, discarded. By the end of the day his new heart took its first tentative beats. A woman's heart. I knew that somewhere a family was grieving. I knew I would never be able to meet them, much less thank them. I knew that suddenly, everything had changed.

I've written for myself about that fateful day many times, and spoken an edited version of my personal experiences in a number of forums. However, it's taken nearly seven years to find the words for other people to read. Re-reading them now, I realise I could tinker with them indefinitely, delaying the moment when I let them go into your care. So what follows is what I also think you should know. The weight of the past still drags me down from time to time — I still hear "that" voice, even if the person is long gone from my life — — but now I see more reasons why I should get up and keep on going. If just one person reads this story, or those of my colleagues and friends, and makes a different choice, then I'll count it a success. I many never know, of course. But you will.

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Wendy remains such a strong presence; she is woven through the stories of my life. She reappears every time a memory comes to the surface. In my home her belongings are everywhere, yet with each clean up something else of hers gets thrown out as it is no longer needed. With each discarded item I get a wave of memories that I worry are also being thrown out, which has seen me pause, in moments in time, resisting change so I can continue to cling to the





past. But as I notice myself growing older, and the world around me changes, recognising that it is time to let go of the past is still an uncomfortable reality. I don't go many days without these memories coming to mind as though they had just happened, which is why I'm often surprised how much time has passed.

At the same time, I continue to work hard to ensure that no one else tries to make that final and permanent choice to end their life. However, I recognise that in all spaces of my life I keep people at an arm's length, to protect myself so that I am not hurt in case they follow through and leave me. This fear has had an impact on my personal relationships and my ability to expose my vulnerability to those I love. But at the same time, I remain determined not to let this control me and wear away at my own wellbeing. Regret isn't a strong enough word to describe the feelings that linger. However, hindsight can be a dangerous beast, keeping you awake at night, filling your head with "what ifs" and "should haves". Try as you might, they don't change the past.

I still feel a sadness that people who are important to me now will never have the opportunity to meet Wendy. Conversely, I'm sad that this person, who remains foundational to my life, will never get to meet those who have come to love me. I think a lot about who Wendy would have been if she was here: the places she might have visited, the things she would have achieved, the people she would have met. I had given her a backpack with the hope that she would travel the world and find a space where she connected, but it was never to be used. I remain disheartened that she didn't think these things might have been possible, and are now too late to realise. I worry that she may only exist as a memory; kept by a few, that fades a little bit more every passing year. At times I wonder if she existed at all. But then the grief revisits me, and is so very real.

The ripples caused by a suicide are never ending. They continue to move outwards and bump into my fragile skin, disturbing the stillness, triggering my own experiences of intense anxiety and depression. But I don't really want to talk about myself. That's another story. Ironically, it forces me to focus back

on this story. Perhaps I should have just done that from the beginning? Maybe next time this is how I might start. I have a sister. Her name is Wendy. She is gay, like me. In June 2007, only a few weeks before her twenty-fifth birthday, she died by suicide. I can't believe how much time has gone by since that day, how much of life she has missed and how much grief I still hold for her. She really had no concept of how much she was loved, and how significant her choice to end her life impacted on the world. My world. And I think it is long past time that she be introduced to those who never had to opportunity to meet her. She would have been glad to meet you. She was a wonderfully vibrant person. And I know you would have liked her too.

**Endings; or new beginnings?**

The process of writing this piece has been a uniquely corporate experience. We have all said things here we have never said anywhere else, much less put into print. We each wrote our stories separately, then met on a humid Friday in early-Autumn Brisbane and fitted them  together. We were slow to start. At morning tea one of the office volunteers brought in a batch of home-made brownies. Their buttery shell soaked the paper towel that doubled as a plate; half an hour later we were hailing them as the sugary kick-start that got us moving. The conversation whipped and turned as we explored our common ground: things we felt we were not allowed to say; and why we should.

Reflecting back on what you've just read, we don't presume to force our conclusions onto you. Some, we hope, are obvious. Far too many people in our community feel their only option is to commit suicide, and many more are considering this option. We feel our community is still in the embryo stages of working out how to change this situation, and the circumstances that might lead to its realisation. While we've detailed an evidence-base to show, to some degree, the extent to which poor mental health and suicide is affecting our combined LGBTI community, we believe on balance that it is not so much *what* we do, but *how* we do it. To support the latter we've shared our personal stories, and hope they'll be received in the spirit in which they





were offered. One of us is happy to stop here. The other two would like to individually close their stories below.

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Over the years I have unpacked my grief, loss, fear, worry and sadness, taking a close look at my internal world with the skilled support of psychologists. This is not always an easy task, and has been a frightening digging close to my scars, feeling a sense of vulnerability that I don't let many people see. Each layer that I unpack reveals another one underneath that in turn demands attention. Seven years on and this task is not yet finished. Each time I step closer to someone to form a connection, walls protecting my vulnerability pop up, preventing me from trusting that this person also won't leave me. With each layer there is the realisation that perhaps Wendy and I are more similar than I thought. And also, perhaps, that her story might have been mine if not for my unlearning of old habits passed down through my family, and the learning of new skills of reflection, communication and mindfulness.

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The purpose of good art is to make people think. For me, the process of writing this piece has been cathartic. As people who work in mental health and suicide prevention, and live it on a daily basis, our lives are often affected by death and distress. Further, we experience behaviours that would not be tolerated in the mainstream communities. It's time for people of all LGBTI genders and sexualities, and for us as a community, to stop "bitchin' in the kitchen" and call ourselves to account. We are often vulnerable and over-exposed. It's time we started naming these experiences — calling our vulnerability for what it is — and finding other words that push our individual experiences into the realm of a commonly shared, safe-space of discussion. We've claimed such a space here; now it's your turn.

## Postscript

This article might have ended at its conclusion had it not been for one reviewer's comments, querying why we had not addressed the issue of contagion, which we understand to be how the process of reporting information about suicide in public places might lead to other people completing suicide in response. As mental health professionals we are well aware of this issue. We have all recently been involved in an LGBTI mental health and suicide prevention project in partnership with some of the organisations listed below. However, we do not address the issue in this article because none of us identified contagion as a limiting factor in why we had previously not spoken out. And, having claimed a space to write, we do not want to let fear dictate how we write, and for who. We do not see this as reckless. Rather, we see this opportunity to tell our stories as the start of a much wider conversation, one that is inclusive of all individual narratives and their circumstances, unencumbered by an explanatory model of suicide that is far from conclusive. We are also mindful, with all our caveats and explanations, that while this piece will be viewed by a select and inquiring audience, we cannot predict what their responses might be; even for us, re-reading this article remains, at times, a harrowing experience. However, what we can do is offer support, and answer questions with honesty about why we have written our stories this way.

Further, we can offer encouragement to reach out and connect**:**

*QLife* – speak to a peer community counsellor on 1800 184 527, or via web chat at www.qlife.org.au. Both services operate 7 days a week from 5:30 – 10:30pm across Australia.

*beyondblue* – speak to a mental health professional on 1300 224 636, available 24 hours a day, seven days a week, or via web chat at www.beyondblue.org.au, available from 3:00pm to midnight.





## Bibliography

Al-Quaderi, Golam Gaus. 2011. Review of Edward Said: A Legacy of Emancipation and Representation, by Adel Iskandar and Hakem Rustom, eds. Transnational Literature 3(2). http://fhrc.flinders.edu.au/transnational/home.html

Anderson-Minshall, Diane. 2012 "Suicide Rate for Trans Women Denied Implants Alarming." *Advocate*. http://www.advocate.com/News/Daily_News/2012/01/01/Suicide_Rate_for_Trans_Women_Denied_Implants_Alarming/

Couch, Murray, Marian Pitts, Hunter Mulcare, Samantha Croy, Anne Mitchell, and Sunil Patel. 2007. *Tranznation: A Report on the Health and Wellbeing of Transgender People in Australian and New Zealand*. Melbourne: LaTrobe University. Australian Research Centre in Sex, Health and Society.

Dean, Roger T. and Hazel Smith, eds. 2009. *Practice-led research, research-led practice in the creative arts*. Edinburgh: University of Edinburgh Press.

Hillier L, T., M. Jones, M. Monagle, N. Overton, L. Gahan, and J. Blackman. 2010. *Writing Themselves In 3: The Third National Report on the Sexual Health and Wellbeing of Same Sex Attracted and Gender Questioning Young People*. Melbourne: La Trobe University: Australian Research Centre in Sex, Health and Society.

Hughes, T., L. A. Szalacha, and R. McNair, R. 2010. "Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women." *Social Science & Medicine* 71: 824-831.

Lhomond, Brigitte and Marie-Josephe Saurel-Cubizolles. 2006. "Violence Against Women and Suicide Risk: The Neglected Impact of Same-Sex Sexual Behaviour." *Social Science & Medicine*, 62: 2002–2013.

Maguen, Shira and Jillian Shiperd. 2010 "Suicide Risk among Transgendered Individuals." *Psychology and Sexuality* 1(1): 34-43.

Mars, Michelle, Sally Morris, and Belinda Marchesiello. 2013. *Cultural Competency Implementation Framework: Achieving Inclusive Practice with*

*Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) Communities*. Sydney, Australia: National LGBTI Health Alliance. http://lgbtihealth.org.au/sites/default/files/Cultural%20Competancy%20Implementation%20Framework.pdf

Marsh, Daniel. 2010. *Suicide: Foucault, History and Truth*. Cambridge: Cambridge University Press.

McDaniel, J. S., D. Purcell, and A. R. D'Augelli. 2011. "The relationship between sexual orientation and risk for suicide: Research findings and future directions for research and prevention." *Suicide & Life-Threatening Behavior*. 31: 84-105.

Mitchell, Anne, William Leonard, Marian Pitts, Anthony Lyons, Anthony Smith, Sunil Patel, Murray Couch, Anna Barrett. (2012). *Private Lives 2: The Second National Survey of the Health and Wellbeing of GLBT Australians*. Melbourne: La Trobe University. Gay and Lesbian Health Victoria (GLHV), and the Australian Research Centre in Sex, Health and Society (ARCSHS).

Pitts, Marian, Anthony Smith, Anne Mitchell and Sunil Patel. 2006. *Private Lives: A Report on the Health and Wellbeing of GLBTI Australians*. Melbourne: LaTrobe University. Australian Research Centre in Sex, Health and Society.

Power, Jennifer. 2011. *Movement, Knowledge, Emotion: Gay Activism and HIV/AIDS in Australia***.** Canberra: ANU E Press. http://press.anu.edu.au/titles/gay_activism_citation/pdf-download/

Rosenstreich, G. 2013. *LGBTI People Mental Health and Suicide*. Sydney: National LGBTI Health Alliance.

Skerrett, D. M., Kõlves, K, & De Leo, D. (in press). "Suicides among LGBT populations in Australia: An analysis of the Queensland Suicide Register." *Asia Pacific Psychiatry*.

Suicide Prevention Australia. 2009. *Position statement: Suicide and self-harm among gay, lesbian, bisexual and transgender communities*. Sydney: Australia.

Testa, R. J., L. M. Sciacca, F. Wang, M. L. Hendricks, P. Goldblum, J. Bradford, and B. Bongar. 2012. "Effects of Violence on Transgender





People." *Professional Psychology: Research and Practice*. 43(15): 452-459.

Weaver, John, and David Wright, eds., 2009. *Histories of Suicide: International Perspectives on Self-Destruction in the Modern World*. Toronto: University of Toronto Press.

Williams, Kenneth. 1993. *The Kenneth Williams Diaries*. London: HarperCollins.